Assessment of USAID/Madagascar Youth Programming and Recommendations for Future Action to improve Reproductive Health Outcomes among Malagasy Youth

Cate Lane, Youth Advisor, USAID Washington

Dr Jocelyne Andriamiadana, Health Advisor, USAID Madagascar

May 30 2012

Executive Summary

Adolescence is a life phase that represents the opportunity to influence future patterns of adult health. Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviors that begin in youth. An improved focus on adolescents and youth is central to the success of many public health agendas, including the Millennium Development Goals and the US Government's Global Health Initiative's efforts to reduce child and maternal mortality and the spread of HIV/AIDS, and to increase the use of family planning and reproductive health services.

In childhood, health issues are related to communicable diseases which can be addressed through simple health interventions. However, for adolescents, morbidity and mortality are more closely related to the adoption of new and potentially unhealthy behaviors which have an immediate impact on adolescent health as well as a long term impact on the incidence of non-communicable diseases, HIV, and maternal morbidity and mortality. To date, many youth health programs have focused on improving sexual and reproductive health outcomes, and in recent years, programs have begun to consider other aspects of health, including the risk factors that influence adolescent health, as well as those factors in a young person's life that act as protective buffers against risk. Programs increasingly focus *less* on the deficits of youth and communities and *more* on the assets of youth and their communities to strengthen the protective factors that mitigate risk and achieve youth resilience to withstand shocks and challenges. This is also known as Positive Youth Development

Madagascar has a young population and the seventh highest rate of early childbearing in the world. Early pregnancies are high risk for both mother and child. Maternal mortality is 498/100,000 women, according to the 2008 DHS, but is believed to have increased since 2009, in part due to significant drops in women's use of public sector health services for antenatal care and delivery and high rates of unsafe abortions. Although young pregnant women and their babies face greater risk nearly two-thirds of young Malagasy women under age 20 deliver at home, many with the assistance of a traditional birth attendant. In addition to beginning childbearing at an early age, young women aged 15-19 experience closely spaced pregnancies. Contraceptive use remains persistently low among all young women, both to delay and/or space pregnancies, despite high levels of knowledge and low levels of opposition to its use. The health sector is a poor source of FP information and services for young people (both married and unmarried), with three quarters of young people reporting they learn about contraception from "other" sources.

USAID Madagascar's current portfolio of programs primarily focuses on unmarried youth aged 15-24 and most programs implement a "treatment approach"-- that is, programs identify specific risk behaviors (unprotected sexual activity, limited use of health services) and directly address the risk behaviors by promoting condom and contraceptive use, use of health services to treat STIs, and voluntary counseling and testing of HIV. There appears to be little attention to health promotion approaches that address some of the factors that facilitate risky behaviors as well as strengthen protective factors. Given the early age of sexual initiation, marriage and childbearing, more effort

needs to be placed on reaching young married women to help them delay pregnancy where feasible, and to access antenatal care, safe childbirth services and postpartum care (including family planning – especially long-acting methods such as IUDs or implants). There is a need to find ways to reach younger adolescents to ensure they are knowledgeable about puberty, fertility and the influence of gender norms, and develop critical communication, negotiation and decision-making skills. There is also an opportunity to create linkages and/or synergies across other sectors beyond health, in line with the Government of Madagascar's efforts to promote a more comprehensive and inter-ministerial response to youth at the national, regional and commune level.

1. Introduction

Adolescence is a life phase that represents the opportunity to influence future patterns of adult health. Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or behaviors that begin in youth. Adolescent health is influenced by early childhood development and the specific biological and social-role changes that accompany puberty. It is further shaped by social determinants[1], as well as internal and external risks and protective factors[2] that affect their ability to adopt positive health behaviors. It is often considered a time of optimal health, yet a 2011 review of mortality trends in 50 countries found that mortality had declined significantly ***less*** for adolescents than for children under 10[3], suggesting many youth around the world are vulnerable to disease, illness and death.

An improved focus on adolescents and youth is central to the success of many public health agendas, including the Millennium Development Goals and the US Government's Global Health Initiative's efforts to reduce child and maternal mortality and the spread of HIV/AIDS, and to increase the use of family planning and reproductive health services. GHI aims to prevent 54 million unintended pregnancies and specifically, to reduce the proportion of women aged 18-24 who have their first birth before age 18. The Global Health Bureau's new Strategic Framework's stated mission of preventing and managing major health challenges of poor, underserved and vulnerable people also suggests the importance of working with young people.

USAID has a long history of working with youth. USAID's Global Health Bureau has implemented two global youth health programs which have compiled a wealth of best practices, lessons learned, tools and resources, many of which are still of use today.[4] Youth remains a technical priority for the Office of Population and Reproductive Health. The Bureau of Economic Growth, Education and the Environment (E3) has also supported global youth programs.[5] Many missions implement youth programming as part of large bilaterals or as specific activities. USAID/Washington conducted a short survey of missions in April 2011 to assess interest in and plans for youth programming. Of the 35 missions who responded, 68% were likely to create a new youth program. Many missions increasingly support holistic programming for youth that encompasses health, education,

[1] WHO defines social determinants of health as the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.

[2] The Center for Disease Control and Protection (CDC) defines *protective factors* as individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events. These factors also increase an individual's ability to avoid risks or hazards, and promote social and emotional competence to thrive in all aspects of life, now and in the future.

[3] Viner RM, Coffey C, Mathers C, et al. 50 year mortality trends in children and young people: a study of 50 low-income,middle-income and high-income countries, Lancet, 2011:377:1162-74

[4] FOCUS on Young Adults was implemented between 1994 and 2000 by Pathfinder International and YouthNet was implemented by FHI360 from 2000 – 2006. Tools and resources from both projects can be found at http://www.fhi360.org/en/youth/youthnet/index.htm

[5] E3 supported EQUIP3 which prepared out-of-school youth for work, civil society and family life, and was implemented by Education Development Center http://www.equip123.net/

employment and civic participation, and plan to use multiple funding sources to create youth programs that work across two or more sectors.

a. Commitment to Achieving the Demographic Dividend: USAID's Youth in Development Policy

Within the Office of Population and Reproductive Health, there is renewed interest in the opportunity engendered by increases in contraceptive use, and potential declines in fertility in many countries, leading to the so-called "demographic dividend."[6] Administrator Shah's 2012 Annual Letter specifically references the role of USAID in helping countries achieve the "demographic dividend," and investments in youth health (including reproductive health), education and employment are a critical aspect of that support.

To more systematically guide and mainstream youth programming across the agency, USAID has developed its first ever Youth in Development Policy, which will be launched in 2012. The policy frames youth programming within a paradigm of "support, protect, prepare and engage" that will enable young people to safely transition to adulthood. The policy positions USAID to effectively program for the "youth bulge" by encouraging USAID missions and programs to ensure adequate attention to youth. Youth programming has traditionally been implemented within specific sectors, including health, education, employment, and civic participation. The policy advocates for greater attention to approaches that are integrated and work across critical sectors and that strengthen youth development systems.[7]

The Policy objectives are to:

1) Strengthen youth programming across all sectors to empower and protect young people and achieve development outcomes;
2) Mainstream and coordinate youth considerations across policies, programs and sectors; and
3) Advance youth participation, innovation and partnership.

USAID's youth development principles are intended to guide collective efforts to achieve the policy objectives. These include:

- Youth participation as vital for effective programs
- Assets based approaches that build youth resilience
- Recognition of youth differences and commonalities
- Second chance opportunities

[6] The World Bank notes that lower fertility and slower population growth, in combination with decreasing mortality—i.e. the demographic transition—increases the proportion of productive individuals relative to dependents. This change creates a "window of opportunity" conducive to economic growth. Countries that exploit this "demographic dividend"—through investments in the education, skills and health of the working-age population while simultaneously creating a favorable macroeconomic policy climate—can experience economic growth and reduction in poverty. Such investments are particularly important in light of the unprecedented numbers of young people now entering their reproductive years. Of the more than 1.7 billion youth aged 10-24, 86% live in developing countries. Investing in the human and social capital of these young people is key to ending the cycle of poverty.

[7] Youth development systems can be defined as a series of partnerships or connections among organizations to plan and deliver a menu of services based on youth development principles.

- Support for mentors, families and communities
- Gender equality
- Innovation and technology

The Policy calls for missions to strategically consider how mainstreaming youth across their portfolios will help them achieve their development objectives, to carefully assess social, economic and political contexts and considerations for youth programming and to program according to age cohort/developmental stage. A new global Agency procurement mechanism (YouthPower) is under development, in part as a strategic effort to "stand up" the policy. YouthPower aims to strengthen and support Mission efforts across and within major sectors (health, education, workforce, civic participation) to identify, evaluate and promote best practices in integration, cross-sectoral synergies and youth development systems.

2. International Evidence and Best Practices in Youth Health Programming

In childhood, health is related to communicable diseases which can be addressed through simple health interventions: immunizations, insecticide treated bednets, and curative treatments for infection (such as oral rehydration therapy and antibiotics for respiratory illnesses). In adolescence, however, morbidity and mortality are more closely related to the adoption of new and potentially unhealthy behaviors such as smoking, alcohol use, and unprotected sexual activity, which have an immediate impact on adolescent health (e.g. HIV infection, high risk pregnancy, unsafe abortion, injury and accidents) as well as a long term impact on the incidence of non-communicable diseases, HIV, and maternal morbidity and mortality.

The majority of youth health programs have focused on improving sexual and reproductive health outcomes, primarily to reduce young people's risk of early pregnancy and HIV/AIDS. In recent years, programs have begun to consider other aspects of health including nutrition, healthy lifestyles, violence, injury, substance abuse, mental health and non-communicable diseases. Furthermore, programmers have begun to look not just at risk factors that influence adolescent health, but at those factors in a young person's life that act as protective buffers against risk. Increasingly, research and program experience show it is neither feasible nor productive to focus on one isolated behavior without addressing a broader set of adolescent health concerns. There is mounting evidence that the most effective interventions do not simply attempt to reduce risk, but incorporate strategies to enhance protective factors. The World Health Organization recommends that youth be provided with the following:

- Information and skills, because youth are still developing physically, emotionally, psychologically and cognitively;
- Safe and supportive environments because youth live in an adult world; and
- Health and counseling services, because youth need a safety net.

The table below summarizes knowledge and evidence of effective youth health programs from developing countries:

Table 1: Best Practices in Adolescent Health Programming

Program Intervention	Programmatic Elements	Strength of Evidence	Select projects and impact evaluation
Curriculum-based school programs	Comprehensive information, including abstinence and contraception/condoms Experiential learning with life skills focus Trained facilitators Links to community services, including health	Strong	Howard and McCabe, 1990 Kirby et al 1991 Kirby et al 2004 Okonofua et al 2003
Clinic-based programs/ "youth friendly services"	Culture/gender appropriate Trained staff Skills focus, including identification and reduction of risk behaviors Confidentiality	Strong	Jemmott et al 2005 Korte et al, 2004 Winter et al 1991
Community-based programs	Comprehensive information Experiential/participatory Gender/age appropriate Links to other services (health, sports, academics, jobs)	Strong	Jemmott et al 1992 Speizer et a 2001 Chao-hua et al 2004
Mass media	Tailored to youth audience Mutually reinforcing messages through multiple channels (school, community) Coordinated with other programs	Strong results re: knowledge Weaker behavioral results	WHO 2005

A 2012 Lancet review of adolescent health programming[8] examines the evolution of youth programs from the early 20th century to the present. Early adolescent programs identified "problem behaviors" (premarital sex, extramarital pregnancy, alcohol use) and focused on messages that advised young people to not engage in that problem behavior (e.g.: "Stay away from sex"), but these approaches proved ineffective.

The next generation of adolescent programs examined the predictors of behaviors; these were often defined as "a lack of knowledge of sexuality and reproductive health" and "a lack of knowledge of and access to contraception and health services" and "a lack of youth policies." The most common response over the last 20-30 years have been what is sometimes called a "treatment approach," which usually involves providing young people with sexuality information and education, access to clinical services and the development of youth reproductive health policies.

[8] Catalano R et al, Worldwide application of prevention science in adolescent health, The Lancet, Adolescent Health Series, April 2012, 32-43

Numerous programs have been piloted in much of the world, especially school-based sexuality education and peer outreach, community-based distribution of condoms to youth and "youth friendly clinics," some with very promising results, but very few programs have been brought to scale.

Information is often provided through peer outreach/education and the media (both mass and traditional forms) and school-based sexuality education (although school-based education is often not comprehensive nor does it integrate known best practices in sexuality education). The provision of clinical services has often lagged behind the provision of information, (especially among programs that promoted abstinence) but efforts to improve youth access to services have included training providers to be "youth friendly," the establishment of specialized youth clinics, the deployment of mobile clinics, the distribution of condoms by peer educators or social marketing programs, and the establishment of referral linkages between outreach and clinical services.

Most youth programs have primarily targeted unmarried adolescents, with the goal of preventing child marriage, delaying sexual initiation and preventing premarital childbearing and/or HIV infection. The focus on ensuring that unmarried adolescent girls were able to safely transition to adulthood without experiencing an unwanted pregnancy or unsafe abortion, or HIV infection however, has neglected the fact that in many countries, the majority of adolescent sexual activity and childbearing occurs within marriage. In some countries, early marriage is actually a risk factor for HIV infection. Married adolescents often "fall through the cracks," neither reached by youth programs nor well-served by maternal and child health programs.

a. New thinking and programmatic directions

While the "treatment approach" continues to be the most common approach in many developing countries, youth programming in high income countries is moving away from single problem/risky behavior prevention interventions towards more comprehensive interventions that include both prevention of risk and promotion of positive behaviors and protective factors. These approaches consider:

- The co-occurrence of "problem behaviors" (early sexual activity, lack of contraception/condom use, drug/alcohol use, coerced/forced sex, poor nutrition, etc) and "predictors" of problem behaviors (lack of knowledge, lack of access to services, poor self-efficacy/self-esteem, lack of power, poverty, harmful gender norms);
- an intentional focus that is *less* on the deficits of youth and communities and *more* on the assets[9] of youth and their communities in an effort to strengthen the protective factors that

[9] Assets are defined as both internal and external. Internal assets include youth's ability to cooperate, communicate, set goals and problem solve and to demonstrate self-efficacy, self-awareness and empathy Communities and families are external assets that provide caring relationships, set positive and clear expectations, and offer opportunities for meaningful participation, which promote the ability to succeed rather than eliminating factors that contribute to failure. The more assets a young person possesses, the more likely they are to survive and thrive, even in the face of risk and challenge.

mitigate risk and achieve youth resilience to withstand shocks and challenges. This is also known as Positive Youth Development.[10]

The research on PYD has mainly been in high income countries, but the findings are promising. A 2009 review of 30 PYD programs found that increasing youth assets (parental monitoring, a mentor, school connectedness, feeling valued by the community) were protective in terms of early sexual initiation and alcohol/tobacco use. The more assets reported by youth exponentially increases protective behaviors and reduces risk. [11],[12] This combined approach has been shown to be effective (both in terms of outcomes and cost) at reducing problem behaviors and improving health. While not widely adopted in lower and middle income countries there are encouraging efforts to adapt and apply them in developing countries.[13] It is an opportune time to accelerate these initial efforts to comprehensively address the known "predictors" at the level of the family, community and peers.

3. Madagascar's Youth

DHS data from 2008 shows that Madagascar has a young population: the median age is 18 years, 50 percent of the population is under the age of 18, and nearly a quarter (23 percent) of the population is aged 10-19 years. The total fertility rate in 2010 has declined to 4.7, and the population is projected to grow at a rate of 2.7 percent from 2010-2030[14]. Maternal mortality is 498/100,000 women, according to the 2008 DHS, but is believed to have increased since 2009, in part due to significant drops in women's use of public sector health services for antenatal care and delivery and high rates of unsafe abortions.[15]

Madagascar has the seventh highest rate of early childbearing in the world: a little over four percent of girls aged 15-19 report having had a child by the age of 15 and by age 18, over one-third (36 percent) has given birth. Among 15-19 year old girls, 17 percent initiated sex before the age of 15. The adolescent birth rate is 127.3/1000 among young women 15-19, compared to an overall birth rate of 37.5 births/1000 women. On average, young women initiate sex by 17 and marry by 19, with early sexual initiation, marriage and childbearing more common among rural than urban teens (29 percent vs. 13 percent).

[10] PYD emphasizes 1) an intentional focus on strengths and positive outcomes that build youth competencies; 2) build strong partnerships with youth; 3) involve and engage all youth in a community; 4) involve communities and stakeholders to ensure systemic change and 5) commitment to the long-term.

[11] http://whqlibdoc.who.int/publications/2004/9241592273.pdf
[12] http://www.search-institute.org/developmental-assets/lists
[13] The planned global YouthPower mechanism is built around this prevention/promotion approach, especially within the context of cross-sectoral programming.
[14] http://www.unicef.org/infobycountry/madagascar_statistics.html
[15] Around one-quarter of Malagasy women report having had an abortion. Worldwide, about 14 percent of all abortions occur to women under the age of 20. WHO estimates that around 25 percent of unsafe abortions in Africa are to women under age 20, while in Asia it is around nine percent. Unmarried adolescents are usually more likely to seek an abortion, and their risk of morbidity and mortality tends to be higher, because they seek abortions later in the pregnancy and are often slow to seek help when complications occur.

Early pregnancies are high risk for both mother[16],[17] and child.[18] Although young pregnant women and their babies face greater risk of illness and death, nearly two-thirds of young Malagasy women under age 20 deliver at home and less than one-third deliver in public sector facilities. Young women cite a lack of money as their main reason for not delivering in a public sector facility (55 percent) as well as concern that no drugs (46 percent) or providers (44 percent) are available. Nearly one quarter of young women worry that no female provider is available (compared to 16 percent of women 20-34) and almost 20 percent of young women state that they need permission to access services (compared to 15 percent of women 20-34). Over half of young women deliver with the assistance of a traditional birth attendant, which likely contributes to the high rates of obstetric fistula among adolescents. (Fistula is the second most common cause of maternal mortality in Madagascar.)

In addition to beginning childbearing at an early age, young women aged 15-19 are also more likely to experience closely spaced pregnancies. USAID recommends that for better maternal and child health outcomes, women should wait two years after giving birth before attempting to become pregnant again.[19] Yet nearly half (44 percent) of young mothers experience short birth to pregnancy intervals of less than two years, with 18 percent of young women experiencing birth to pregnancy intervals of 7 – 17 months and 25 percent experiencing intervals of 18-23 months.

Young women have high levels of knowledge of modern contraception, with 92 percent able to name a modern method, yet contraceptive use remains persistently low among all young women, both to delay and/or space pregnancies. Among all sexually active women aged 15 – 19 (both within and outside of union) only 7.5 percent report use of a modern method (and an additional five percent report using a traditional method). The preferred modern method is injectables, followed by pills, condoms and lactational amenorrhea method (LAM), with negligible use of long-acting methods such as implants or IUDs. Despite low levels of use, young women do not appear to be vehemently opposed to contraception: only nine percent said they were opposed to its use and four percent said their husband opposed its use. Four percent said they had no or infrequent sex, four percent had no knowledge of FP and around two percent said there were no services available.

Given such high levels of knowledge, young women are clearly exposed to information about contraception, but the quality of their information is unclear. Three quarters said they learned about contraception from "other" sources (perhaps from community sources and social networks such as friends or peer educators), while 23 percent had heard about contraception on the radio, 10 percent from television and around three percent from reading.

[16] In developing countries, young women under age 20 are twice as likely to die in childbirth as women over 20, and young women under age 15 are five times as likely to die in childbirth.

[17] UNFPA Madagascar believes that nearly one-third of maternal mortality may be among adolescents aged 15-19. Although no data was provided to substantiate this estimate, UNFPA indicated that they plan to support maternal death audits to better describe women who die in childbirth.

[18] Globally, children of adolescent mothers have a 34% higher risk of death in the neonatal period, and a 26% higher risk of death by age five.

[19] http://www.usaid.gov/our_work/global_health/pop/techareas/birthspacing/index.html

The health system however, is an extremely poor source of information for young women. Of those young women 15-19 who had had contact with the health system (either a community health worker or a primary health center) 92 percent said that FP was never discussed with them. Around 20 percent of young women reported having visited a health center, but only six percent reported that FP was discussed. In fact, among all women interviewed by the DHS, health workers appeared to more likely to discuss FP with women aged 25 – 35 and somewhat less likely to discuss with women under 25 or women over 35.

4. Youth Programming in Madagascar

There is a diverse array of actors working to improve adolescent health in Madagascar as government agencies, multi-lateral and bilateral donors and donor supported projects and activities. Select programs are described below:

a. Ministry of Youth

The Ministry of Youth (MoY) coordinates all youth focused programming and activities in Madagascar for youth aged 10-24, both in and out-of-school. It is the responsible agency for reporting on youth aspects of the Madagascar Plan of Action. Since there are programs in school, the MoY pays special attention to out-of-school youth, which could include married adolescent girls if they are interested. They have begun to address family level risk factors, and have developed parenting education programs for both in-school and out-of-school youth. In the past, the MoY focused on youth reproductive health, but since 2010 they have looked at adolescent health and wellbeing more broadly. The MoY will be collaborating with the University of Medicine, UNICEF and the University of Lausanne to implement pre-service training in youth friendly care for medical and paramedical students.

The MoY is guided by the Madagascar Action Plan (MAP) which addresses youth under ***Engagement No 3 – Transformation de l'education*** and ***Engagement No 5 – Sante et planning familial***. Under Engagement No 3, the government aims to improve the quality of and access to both primary and secondary education for all young people, as well as strengthen youth development efforts. Youth development encompasses improving opportunities for sports and recreation as well as for mentoring and socio-professional opportunities. Under Engagement No 5, youth are not specifically identified but are indirectly referenced (e.g. develop preventive care for pregnant women and improve the management of risky and complicated pregnancies; increase access to family planning services and products).

A national inter-ministerial committee is tasked with ensuring the objectives of the MAP with regard to youth are met; however, most of the actual work occurs at the level of the Maisons des Jeunes, which are youth friendly centers. Nationally, there are 40 Maisons des Jeunes (with about 25 actually functional; UNFPA and UNICEF are supporting the rehabilitation of the other 15 Maisons des Jeunes). Each Maison des Jeunes is expected to establish an inter-ministerial committee made up of representatives from health, tourism, education, environment, justice; in sum, any government sector that has an impact on youth. The committee ensures various services

are "youth friendly,"[20] coordinates programs, jointly organizes events, and promotes referral linkages across sectors. The MoY supports youth access to reproductive health and family planning information and services, within the context of overall youth health promotion. The MoY representative (Dr Tiffana) noted that PSI is very active in this committee at the national and commune level, and she requested that Santénet2 begin to more actively participate in the committees than they have to date.

The Maisons des Jeunes provide education and training to youth on sexuality and reproductive health, nutrition, violence, civic rights and culture as well as environmental/conservation activities, recreational services, and internet access. A main activity is to officially register youth so that they can get an identity card. There are currently around 600 peer educators who are attached to the Maisons, with plans to expand to 1000. At the commune level, youth organizations are expected to form a youth council to ensure collaboration and coordination of activities. There are 198 youth councils.

The MoY also implements a program for youth entrepreneurship, as part of an initiative by the Conference of Ministries of Youth and Sports of the Francophone Countries (CONFEJES), a 43 member body, which is financially supported by all members through annual contributions. Each year, Madagascar identifies around 70 outstanding youth entrepreneurs aged 16-30 (representing 15 of the 22 regions) and works with them to submit business proposals to CONFEJES. Ten youth are selected and awarded approximately 7 million ariary over a three year period to implement their business plan. An evaluation of the program found overall success among the participants.

b. UN Agencies: UNFPA and UNICEF

Both UN agencies work closely with the MoY. UNFPA's areas of interest include early pregnancy, HIV, STIs, unsafe abortion, high risk delivery and fistula, since the majority of fistula cases occur in women under the age of 25, and adolescents make up a significant proportion of women who die of pregnancy-related causes. UNFPA supports the delivery of sexual and reproductive health (SRH) information through "youth centers" in colleges. UNFPA has equipped three youth centers (in Antananarivo, Adoany, and one other community) with games, videos, recreational equipment and materials , with plans to expand the youth center approach to UNFPA's six focal regions (five in the south and one in the north).

UNFPA is aware that these urban-based centers have very limited reach and they collaborate with UNICEF, the Ministry of Health and the MoY to reach rural and out of school youth by better linking youth corners with Maison des Jeunes. They are providing support to the MoY to rehabilitate the Maison des Jeunes. [21] UNFPA attempts to link youth centers to youth friendly services in health

[20] "Youth friendliness" is ensured through training of staff, management tools and reporting although it was noted that data is often of poor quality.

[21] An evaluation of 14 centers in Africa by Population Council, as well as other evaluations in Latin America, however have found that the youth center approach is not very effective in reaching youth with reproductive health information and services: they typically serve small numbers of youth (often older males), are not particularly conducive to the delivery of reproductive health information and services, and are relatively expensive.

centers, and they have trained health workers on youth friendly approaches and provided drugs and FP methods to 10 public sector health centers and 10 NGOs that provide services. They have also established a gender program and provide counseling on gender-based violence and family issues at gender centers. Finally, UNFPA trains youth leaders in advocacy, and provides opportunities for youth to discuss their issues and concerns around policies and programs.

UNICEF works with the MoY and NGOs to address needs of youth aged 10 – 19. UNICEF provides coordination and capacity building to the MoY chaired National Inter-ministerial Committee on Youth (members include Justice, Population, Health, Education and other actors interested in youth programs), implements community based prevention activities for youth development and health and advocates for recognition of youth rights.

According to UNICEF, the national inter-ministerial committee is in the process of developing a national plan of action for youth that is human rights based, promotes equity and results-based management, and reflects the reality and integrated needs of youth, including health. Six regional committees have also been established that will adapt the national plan as needed once it is complete. The plan will reflect sector specific priorities and services that need to be provided, and will share information, and identify opportunities to collaborate.

UNICEF supports 225 peer educators aged 15 – 24 both in and out of school in eight regions. (However, they may even recruit and train youth as young as 13 if they have the capacity, since UNICEF's target audience is 10-19.) They are working with the MoY to revamp their peer education training, and plan to train peer educators and develop action plans by the end of June in target regions. They are also establishing "information kiosks" especially for out-of-school youth; both peer educators and kiosks will refer youth to Maisons des Jeunes. UNICEF provides funding for a youth hotline as part of the National AIDS Committee portfolio.

UNICEF has developed a parenting education program to facilitate parent-child communication, to be piloted in schools in one region. They are also working with Ministry of Health, the University Medical School and the University of Lausanne to integrate adolescent health into pre-service training of doctors and paramedics. UNICEF hopes to create a multi-disciplinary outpatient "case center" unit (or a referral center for specialized care) for adolescents at the hospital which will provide care for adolescents as well as practical experience for students.

UNICEF is also working with the Ministry of Education to integrate sexuality education into pre-service training for teachers and will be participating in a May 2012 UNESCO meeting in Tanzania to develop pre-service training guidelines for secondary school teachers. (UNESCO was instrumental in developing international guidelines for sexuality education in schools.)

c. US Embassy

The US Embassy is interested in preparing youth to be good citizens and leaders by improving their understanding of democracy, strengthening youth development efforts, and addressing the numerous cultural and social barriers to youth participation and initiative in Madagascar. The

Embassy launched a Youth Civic Centre (YCC) in February 2012 in Antananarivo. The goal of the YCC is to develop a long term vision for youth development in Madagascar, and to provide a platform to ensure youth voice in social development. It is currently located within the Madagascar Development Learning Center (MDLC), which is supported by World Bank.

The program recruits youth professionals and leaders aged 18-35 for a training in leadership skills and civic engagement, which is implemented by a German foundation. The Embassy has also exposed Malagasy youth leaders to the experiences of young American political activists who organized US youth to participate in the 2008 election process, especially through the use of social media.

The Embassy is working with 20 youth association, including an umbrella organization of youth serving NGOs, Scouts (Boys/Girls), student associations, UN Clubs, YMCA/YWCA, youth arms of service clubs (Lions, Rotary, etc.), young entrepreneurs, and young journalists. A provisional committee has been established to create terms of reference for the YCC. A priority activity for the committee is to develop an advocacy plan for a Government Youth Agenda, to include presenting a statement to the government on youth issues.

The program has engaged with the media through sponsoring debates on the Cause Liberte television program. To date, they have addressed premarital counseling as a strategy to address domestic violence, and the importance of education and environmental preservation. Viewers are encouraged to vote on issues raised on the program via SMS.

d. USAID Projects: Santénet2, Marie Stopes Madagascar, Population Services International, and Mahefa

Santénet2: In 2010, Santénet2 launched an activity intended to build the leadership and technical skills of 1200 youth leaders in 599 KM Salama communes so that they could organize discussions and other information dissemination activities for youth on reproductive health, family planning, HIV/STIs, drugs/alcohol at the commune level. Local NGOs (including CARE and Catholic Relief Services) were awarded funds to supervise the work of the youth leaders. Interested in obtaining feedback on best practices of the youth leaders as well as their challenges and to identify potential solutions, Santénet2 conducted five two-day youth forums in the different regions where Santénet2 works, beginning with a pilot activity in Tamatave.

Twenty-four male and female youth leaders and eight NGO technical representatives attended the Tamatave forum. The Youth Forum, while providing an opportunity for youth to report their successes and share their concerns, also revealed some significant weaknesses in the activity, including limited youth participation (in the selection of youth leaders and in the planning and implementation of the Youth Forum); a lack of understanding among youth leaders of their roles and responsibilities; a lack of clarity as to where youth leaders fit within the formal structure of community health centers, community health committees and community health agents; and a need for more training/skills development, supervision, and materials. A review of available literature regarding best and promising practices in the implementation of peer education programs would

provide Santénet2 staff with additional insights that should strengthen this activity. (More detailed information on the Youth Forum appear on the Trip Report)

Marie Stopes Madagascar (MSM) MSM runs 15 family planning centers in urban areas including four in Antananarivo, one in Tamatave, and two maternity hospitals. Their Blue Star provider network is made up of 140 doctors who are mainly based in peri-urban settings. Approximately 30% of their clients are under the age of 22[22]. MSM provides training to their Blue Star members on FP methods and quality service delivery, and are strengthening provider skills in long acting and permanent methods, particularly implants and IUDs. Funding from the Support to International Family Planning Organizations (SIFPO) project will enable MSM to work with Marie Stopes International to better integrate youth friendly approaches into select service delivery activities in a systematic, standardized and sustained way, and to expand and train their Blue Star network members.

Locally, they are implementing a number of programs to increase demand for FP services. They are also receiving World Bank funding to revitalize their HIV VCT services. Specific activities include the following:

- Community health educators (CHEs)[23] and peer educators work with schools and with youth groups to provide information on reproductive health (RH) and FP). In urban areas, outreach workers refer youth to Marie Stops FP centers and maternity centers. CHEs distribute vouchers to poor clients who can present the voucher to a Blue Star provider for a long-term method. They are exploring how to use a voucher system for youth, but since youth are often more interested in short term or emergency methods they have not yet found this to be a cost effective strategy.
- Mobile clinics provide LAPM to rural women. MSM used to work directly with the primary health centers (CSBs), but since CSBs and CHAs provide short term methods, MSM mobile teams have been reoriented to provide IUD, implants, tubal ligations and vasectomies at the village level. CHEs go out in advance of mobile teams to mobilize communities and mobile teams provide services about three months after CHEs are deployed. CHEs then follow up post clinic to ensure there are no problems or concerns. MSM would like to work with Santénet2 CHAs and Youth Leaders, especially to reach youth, including first time mothers who may be interested in a long-acting method to delay or better space pregnancy.
- MSM is launching a new youth project in two regions of the East Coast to treat STIs, and to reach husbands who influence FP decision-making. This activity is more community driven and will focus on helping men understand the health and social benefits of FP. MSM also provides post-abortion care services (though not with USAID funding) and many of their clients are youth.
- Marie Stopes Ladies (MS Ladies) are 17 state qualified paramedics who are part-time employees, loosely attached to peri-urban MSM centers and CSBs. They are "roving" providers who raise community awareness and provide long acting and short term methods

[22] This is the level of age disaggregation in monthly reporting, although they can obtain age specific data from clinic registers

[23] The CHEs are salaried employees with good communication skills and good relations with communities and CHAs.

in the client's home. Nearly every MSM center has an MS Lady; it is a very cost-effective service and they hope to add more MS Ladies.

Population Services International (PSI) PSI's Top Reseau program started about 10 years ago with a focus on youth but they have since diversified to provide reproductive and sexual health and family planning services, counseling, treatment for STIs, VCT for HIV, and referral for HIV + clients to a wider population One of the Top Reseau doctors is Dr Rabehanta. He sees around five to eight youth per day, and sometimes as many as 16, ranging in age from 13 – 35, although PSI's target audience is 15-24. Men mainly come for STI treatment, while women come for FP and STI treatment. The preferred method of FP is oral contraceptives and condoms. While he provides implants, he feels implants are more appropriate for married women, sex workers and Most At Risk Populations (MARPs) who do not want to become pregnant. He likes serving youth and wishes he had more space, especially a room where youth could meet to discuss health issues.

Teams of peer educators (two per team)[24] recruit youth in the community and invite them to a location (in this case the clinic, but also youth clubs and schools) where youth view one of four different PSI educational videos (STIs, HIV, FP and one other) and participate in an educational discussion. In this instance, there were 10-12 youth (both boys and girls) who were on average about age 16. The sessions are intended to increase youth perception of risk and improve their knowledge of prevention and where to obtain services.

Mahefa This project is in the process of developing its workplan and is still strategizing on how to reach youth. Two considerations include how to mainstream youth across all activities to address unmet need for FP and low use of services, and the integration of select activities developed under the Ankoay project (including the Red Card activity).

4. Analysis and Recommendations for Strengthened Youth Programming with Current and Future Activities

USAID's current portfolio of programs primarily implements a "treatment approach"-- that is, programs identify specific risk behaviors (e.g. unprotected sexual activity, limited use of health services) and directly address the risk behaviors by promoting condom use, contraceptive use, use of health services to treat STIs, voluntary counseling and testing of HIV, etc. There appears to be little attention to health promotion approaches that address some of the factors that facilitate risky behaviors as well as strengthen protective factors. Programs should identify strategies and activities that go beyond "treatment" to address these factors, and where possible, evaluate whether or not these types of activities enhance program outcomes.

The majority of interventions appear to be targeted to unmarried youth, within the age range of 15 – 24. Given the early age of sexual initiation, marriage and childbearing, more effort needs to be placed on reaching young married women to help them delay pregnancy where feasible, and to access antenatal care, safe childbirth services and postpartum care (including family planning). It

[24] Peer educators are in their early 20s, carefully selected for the communication skills and outgoing personalities. They are well-trained and are salaried employees of PSI.

would also be strategic to identify opportunities to reach younger adolescents (10-14); although targeting this age group is sometimes seen as controversial, age appropriate interventions (including those that involve parents, communities and religious leaders) are available that ensure very young adolescents are knowledgeable about puberty, fertility and the influence of gender norms, and develop critical communication, negotiation and decision-making skills.[25],[26]

All projects should explore strategies to expand adolescent access to long acting methods. PSI/Mali and FHI360 in Kenya have had some interesting success with the promotion of implants to both married and unmarried adolescents, and there is also anecdotal evidence of demand for implants among youth clients of Marie Stopes/Tanzania. The provision of FP methods to adolescents is often closely associated with provider bias as to what methods youth should or should not use, and many providers remain uncomfortable with providing hormonal or long-acting methods to adolescents. Some providers feel the provision of methods may encourage sexual activity, or that hormonal methods may negatively affect fertility.

The majority of programs appear to be health sector specific, with limited attempts to create linkages and/or synergies across other sectors. Although USAID is at present prohibited from working directly with the Government of Madagascar, programs working with youth should identify how they can work with the MoY, the Maisons des Jeunes, and the inter-ministerial committee and youth councils at the national, regional and commune level.

If and when the political crisis resolves and USAID is able to work with government, USAID should consider providing active support to the MoY to strengthen and expand the inter-ministerial youth committees at the national and commune level to go beyond coordination and information sharing and promote cross-sectoral planning, implementation and evaluation between health and other sectors that reach youth, especially employment and education.

a. Youth Focus for the Community-Based Primary Health Care Project:

Based on the concept note design, the contractor should implement the following activities to strengthen outreach, education and service delivery to Malagasy youth. A number of tools and resources have been developed that can be found on the FHI360 YouthNet website, including provider training resources, assessment tools, and sexuality education curricula. Other tools include job aids developed by the World Health Organization to enhance provision of youth friendly services[27] and a tool to assess the quality of youth friendly services developed by Pathfinder International.[28] Where possible, the contractor should make use of existing tools, program models and resources, including those that have been developed in Madagascar (such as the Ankoay materials) adapting as needed for cultural and language context.

[25] http://www.irh.org/?q=content/fam-body-literacy-fertility-awareness-very-young-adolescents.
[26] http://www.plannedparenthood.org/nyc/files/NYC/CFL_Guide_web.pdf

[27] http://www.who.int/maternal_child_adolescent/documents/9789241599962/en/index.html
[28] http://www.pathfind.org/site/DocServer/YFPAC_assessment_tool.pdf?docID=13121

1) Strengthen cross-sectoral partnerships between health focused projects and other youth-serving organizations to ensure a more holistic approach and cross-sectoral synergies.[29] This should include improved collaboration between USAID partners, as well as active participation in the MoY's inter-ministerial committees and local Youth Councils.
2) Ensure capacity for collection and analysis of age disaggregated data (in five year increments: 10-14, 15-19 and 20-24) for improved programming and to assess youth results. Strengthen the capacity of youth leaders, CHVs, and communities to use data to strengthen services.
3) Ensure adequate opportunities for youth participation in project activities. Illustrative examples include the formation of a project youth advisory committee, youth involvement in the selection of youth leaders/peer educators, youth representation in commune level Social Development Committees, youth involvement in assessments and evaluations of project activities, etc. The project will collaborate and coordinate with the US Embassy Youth Council to incorporate reproductive health concerns into youth issues addressed by Youth Council, including the development of the advocacy plan for a Government Youth Agenda, the statement to the government on youth issues and engagement with the media.
4) Build community awareness and ownership of youth health issues and concerns through use of participatory, community development methodologies such as The Community Action Cycle[30] or Partnership Defined Quality[31] to ensure the development of community appropriate, sustained solutions to youth health concerns. These tools have been used and validated in many countries to build the capacity of communities to address critical community development needs, whether as broadly defined community development priorities, or specific concern, such as early pregnancy, adolescent mortality or quality of health services.
5) Expand the number of Youth Leaders in the communes, ensure adequate training (both pre and in-service) in technical content and appropriate skills, and guarantee formal and systematic collaboration between CHAs, SDCs and COSANs and Youth Leaders. Youth leaders should be able to confidently refer youth to CHVs for contraception and other services, and CHVs can support Youth Leaders to improve youth access to short-term FP methods. In addition, the program should identify strategies to expand the benefits of peer education training to as many young people as possible, since evaluations of peer education programs suggest that the majority of positive changes do not occur among target groups, but among peer educators themselves. The application of social network theory may be a more effective way to expand youth access to information than peer education or youth leader strategies.

[29] Employment is a priority for many youth, and good health is an important component of one's ability to work. Early and unplanned pregnancy contribute to poverty among young women, and unemployment contributes to HIV risk among youth, yet many employment programs do not see reproductive health as part of their mandate. The international Youth Foundation has been working to link workforce and youth development with reproductive health education: http://www.iyfnet.org/planning-for-life.

[30] http://www.comminit.com/global/content/community-mobilisation-community-action-cycle
[31] http://archive.k4health.org/toolkits/pc-bcc/partnership-defined-quality-pdq

6) The program should improve the availability of and access to community primary health care for youth, to include in-depth assessment of provider biases and attitudes toward providing RH/FP services to both married and unmarried youth to prevent, delay and/or space pregnancies, as well as in-depth assessments of youth biases and attitudes towards family planning and the use of available health services. Based on assessment findings, the contractor will 1) develop and provide training to CHVs in youth friendly approaches that increase provider understanding of adolescent development and risks of early, first pregnancies; address judgmental attitudes (including towards the provision of long-acting methods for youth[32] and improve provider communication and counseling skills.[33], [34], [35] 2) develop and implement a focused antenatal and postpartum care package for CHVs to provide to pregnant adolescents that promotes improved access to antenatal care, safe childbirth services and postpartum family planning [36],[37] and discusses the health and social benefits of using family planning for healthy timing and spacing of pregnancy with young women, their spouses, families, communities, husbands, and religious leaders and 4) work with professional provider networks (doctors, paramedics, pharmacists) to improve their capacity to provide "youth friendly" services:[38],[39] including the provision of long-acting methods.
7) Implement enter-educate approaches especially on community radio. Support the development of radio dramas, discussion and call-in programs, etc to provide information to youth, and ensure that efforts to raise awareness are also linked to service delivery (e.g. Marie Stopes mobile clinics, CHV campaigns, etc) so that youth can act on information. "Traveling video units" are often an important source of entertainment in rural or slum areas, and can be utilized for airing socially responsible videos on youth health issues, that can be followed by group discussions. Local drama, cultural groups and musicians should be engaged to develop socially relevant and culturally appropriate dramas and music. Popular sports leaders can promote positive behaviors.
8) Implement technologically innovative approaches, such as the use of SMS and social media to provide information to youth and make referrals.[40]
9) Integrate and evaluate positive youth development (PYD) approaches that not only "treat problems" but build youth, family and community assets to increase youth resilience and lead to positive youth health outcomes. There is a need to build the evidence base around the implementation and results of PYD approaches in low and middle-income countries. The Ankoay approach, identified as a national best practice and widely used in Madagascar appears to promote many aspects of PYD. This project should assess and validate the

[32] http://www.esdproj.org/site/PageNavigator/Themes_Spacing,
[33] http://www.pathfind.org/site/DocServer/Training_Manual_PDFs-combined.pdf?docID=7601
[34] http://www.ippf.org/NR/rdonlyres/61BA967F-5D07-41EA-907D-C8AB128E002D/0/InspireProvide.pdf
[35] See also training materials to be developed by Marie Stopes
[36] http://www.who.int/maternal_child_adolescent/documents/mpsnnotes_2_lr.pdf
[37] http://www.popcouncil.org/pdfs/2012RH_APHIAII_MarriedAdolGirlsEval.pdf
[38] http://www.who.int/maternal_child_adolescent/documents/youth_hiv_reproductive_health/en/index.html
[39] http://www.path.org/publications/detail.php?i=860
[40] http://www.fhi360.org/en/Research/Projects/Progress/GTL/mobile_tech.htm

Ankoay approach against desired youth outcomes, such as delay in sexual initiation, delay of first pregnancy, increased use of family planning, etc.

10) Greater attention to gender, as gendered behaviors emerge during adolescence, and gender norms must be addressed by youth programs. Young men are often not well-reached by RH/FP programs. PROMUNDO/Program H [41] has been used in many countries to help young men better understand issues of masculinity and how it affects their health and wellbeing as well as that of their partners. Stepping Stones is also another best practice that addresses gender and gender-based violence[42].
11) Propose approaches to work with government, if and when political crisis resolves, such as pre and in-service training of government health workers, in collaboration with the MoY, Ministry of Health and University Medical School, strengthening of inter-ministerial collaboration, especially to enable cross-sectoral synergies and application of PYD, advocacy for the development of a government Youth Agenda, development and/or enforcement of needed policy related to youth, etc.

[41] http://www.promundo.org.br/en/activities/activities-posts/program-h/
[42] http://www.steppingstonesfeedback.org/index.php/page/Resources/gb?resourceid=20